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Medical Director's Update for Base Station Physicians' Committee
April, 2008

Safe Surrender: The safe surrender program is scheduled to expand into fire stations at the end of April. This will allow a child's caretaker to surrender the infant anonymously within 72 hours of birth. The program seeks to prevent deaths of abandoned infants in restrooms, dumpsters and other locations. Training is underway and should include anyone stationed in a fire house so they can receive the surrendered infant if necessary. Procedures allow the infant to be identified by the mother or other surrendering caretaker for a period afterward, so they may reclaim the child. An important part of the surrender process is the family medical history document included in the supply packets. The surrender period may be the only time important family medical history is obtained, and a maximum effort should be made to get the family to complete the history form before they leave the station. The surrendering person has the right to take the form, complete it later, and mail it in. This seems less likely to result in a completed form, so I would encourage all personnel to get the family to complete the form in the station, or impress upon them the importance of returning the form if they do say they will complete it later.

Bypass/Off Load Delays: Bypass hours and the number of patients who bypass the requested hospital are down from earlier in the year, but still substantial. As mentioned last month, we have experienced some off load delays. Hospitals are taking a variety of actions to improve the situation and we are in frequent contact with them. Upon the suggestion of EMOC, EMS is looking at memorializing in the bypass policy some of the changes instituted in the last few years. Hospitals are reminded to use the Capacity Plan to maintain the ability to take patients, and hopeful, hold as few patients as possible for admission. Hospital staff should make every effort to greet arriving field personnel with eye contact and information about the current status. Hospital staff should also remember they are responsible for the patient upon arrival, both for assessment and ongoing treatment. We continue to work with the hospitals and field on specific issues. EMS thanks everyone, field and hospital based, working so hard to make the system work for patients. Thanks.

EMS: Please welcome Karen Crie as the new administrative assistant in EMS working with myself and Marcy. Karen comes to us from outside the county, with extensive experience in small

business.

AHA CPR: The American Heart Association changed its recommendations for bystander CPR two weeks ago in a science advisory designed to increase the number of arrest victims who receive bystander CPR. “When an adult suddenly collapses, trained or untrained bystanders should—at a minimum—activate their community emergency medical response system (eg, call 911) and provide high-quality chest compressions by pushing hard and fast in the center of the chest, minimizing interruptions” the advisory states. Bystanders not trained in CPR should provide “hands-only” CPR. A bystander previously trained in CPR could provide either conventional 30:2 CPR or hands-only CPR. Anyone not confidant in their ability to provide conventional CPR should perform hands-only CPR. Hands-only CPR should be continued until an AED arrives and is ready for use or EMS providers take over care of the patient. The advisory does not address professional rescuers. It focuses on adults or children with sudden collapse likely from a cardiac cause. The AHA encourages the public to obtain CPR training, since it includes skills applicable to those with asphyxial arrest, including children, and those with airway obstruction, drowning, respiratory diseases, apnea and other causes of hypoventilation.

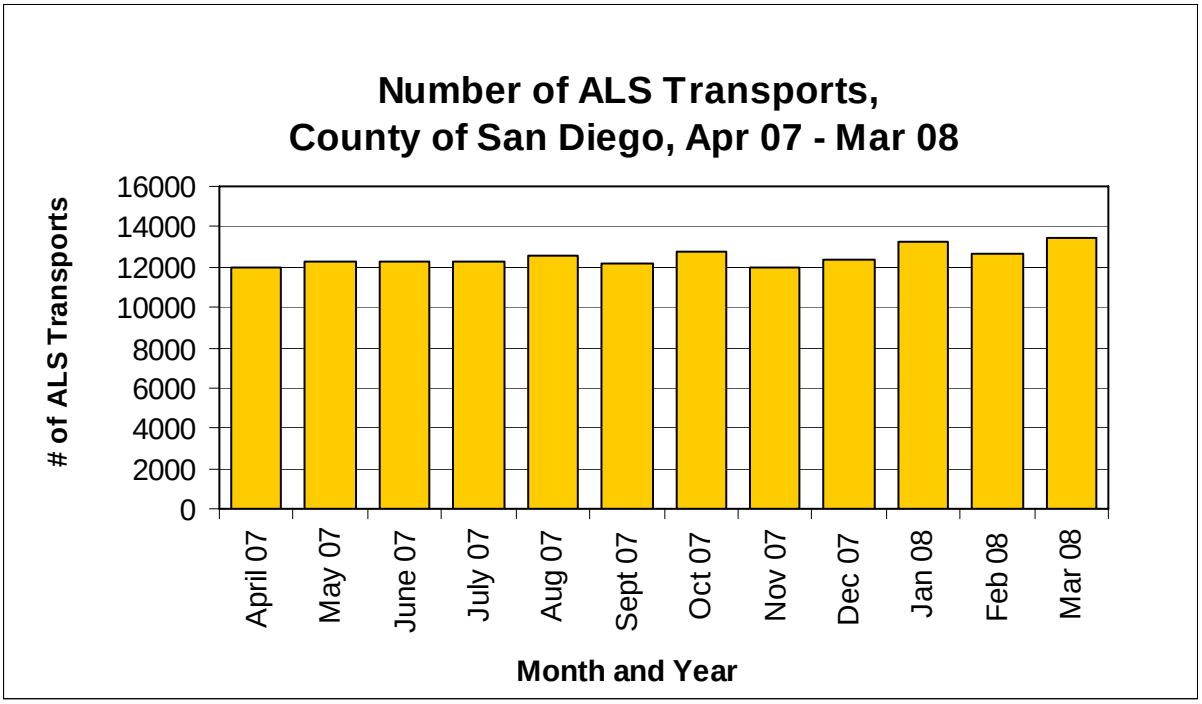
Infectious Disease: A new infectious disease exposure policy will be released soon. Please review that when it is out. Remember the first step is to ascertain there has been an exposure, defined as a contact that can result in transmission of the infectious agent. Another critical issue is the importance of starting prophylaxis for HIV within the first several hours of the exposure to minimize the chance of contracting the disease. New procedures are being developed for Designated Officers (field providers), the Medical Examiner, Public Health lab and EMS for exposures resulting from patients who are medical examiner cases. We will keep providers informed as this develops.

STEMI: Door to balloon times are excellent for activated patients. For the system’s first year, the median door to balloon time for activated patients was 62 minutes. That’s a remarkable achievement for both the field and the hospitals working together. The reduction in door to balloon times will lower death rates and improve outcomes of STEMI patients. Of all activated PCI patients, 89% had their procedure within 90 minutes. Thank you for all your work on this. Remember that acceptable quality EKGs are important to avoid false positives. There was a spike in false positive cases in the fourth quarter. We encourage the field to read the entire interpretation to give the base a chance to hear the complete interpretation. This also may help with false positives, or give important information. Mimics like atrial flutter and other SVTs also cause false positive EKGs. Pacemakers will frequently be read as STEMIs. In addition, patients with symptoms that are not typical of MI are more likely to end up with false positive EKGs.

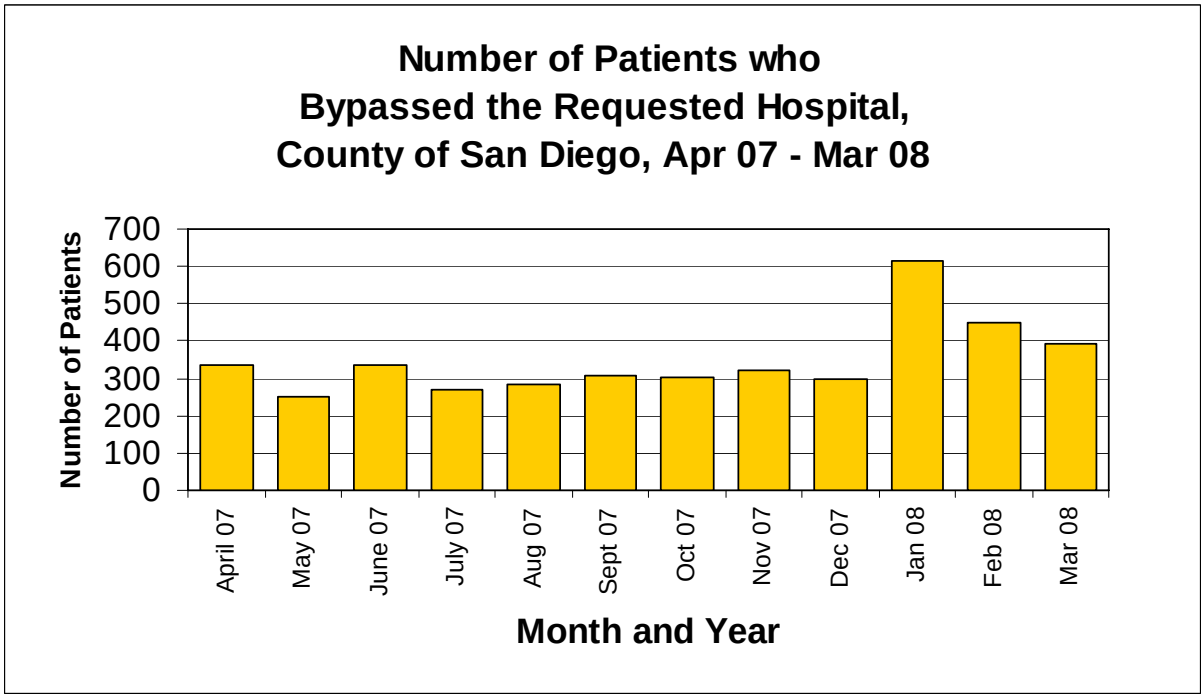
In-service: CPAP will be added as a treatment for respiratory distress patients, with a particular focus on pulmonary edema. CPAC is working to select uniform CPAP equipment in the county. The focus on pulmonary edema includes getting CHF patients early nitroglycerine, reserving albuterol and Atrovent for patients with possible mixed pulmonary/cardiac disease, rather than initial focus on wheezing. Midazolam will be added as a treatment option for severely agitated patients, especially those with agitated delirium or stimulant intoxication. Information on Taser use will be included as well.

Stroke: Hospital reviews for the new destination policy will occur this summer. More information will be available then on any system impact or changes.

POLST: There is interest in a new intensity of treatment form called the POLST, or Physician Orders for Life-Sustaining Treatment. This is used in Oregon and is attracting interest here in California. The POLST has resuscitation preferences or DNR information, but also includes patient desires for comfort measures only, limited additional interventions, or full treatment. There are separate areas for antibiotics and artificially administered nutrition. We will keep you posted.
Below are the patient destination data in graphic form:



Source: County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services, MICN Records, Apr 2007 – Mar 2008 Note: Numbers based on Run Outcomes of Transport by Unit and Transport by Other



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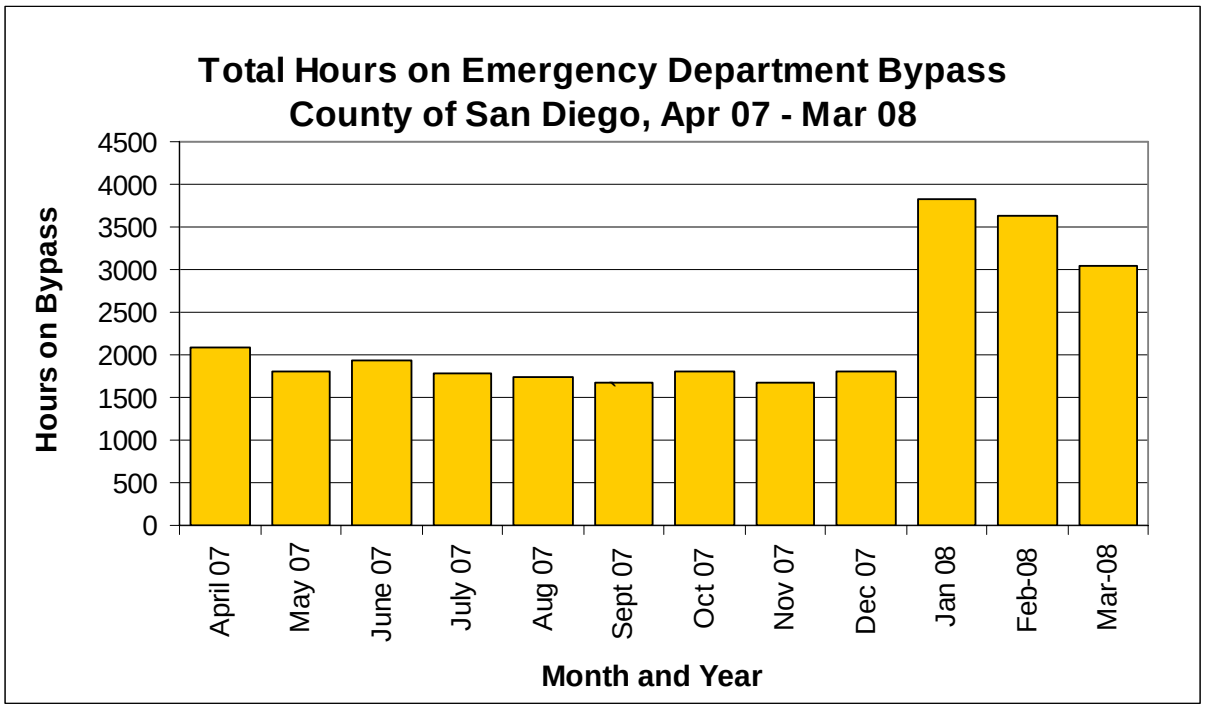

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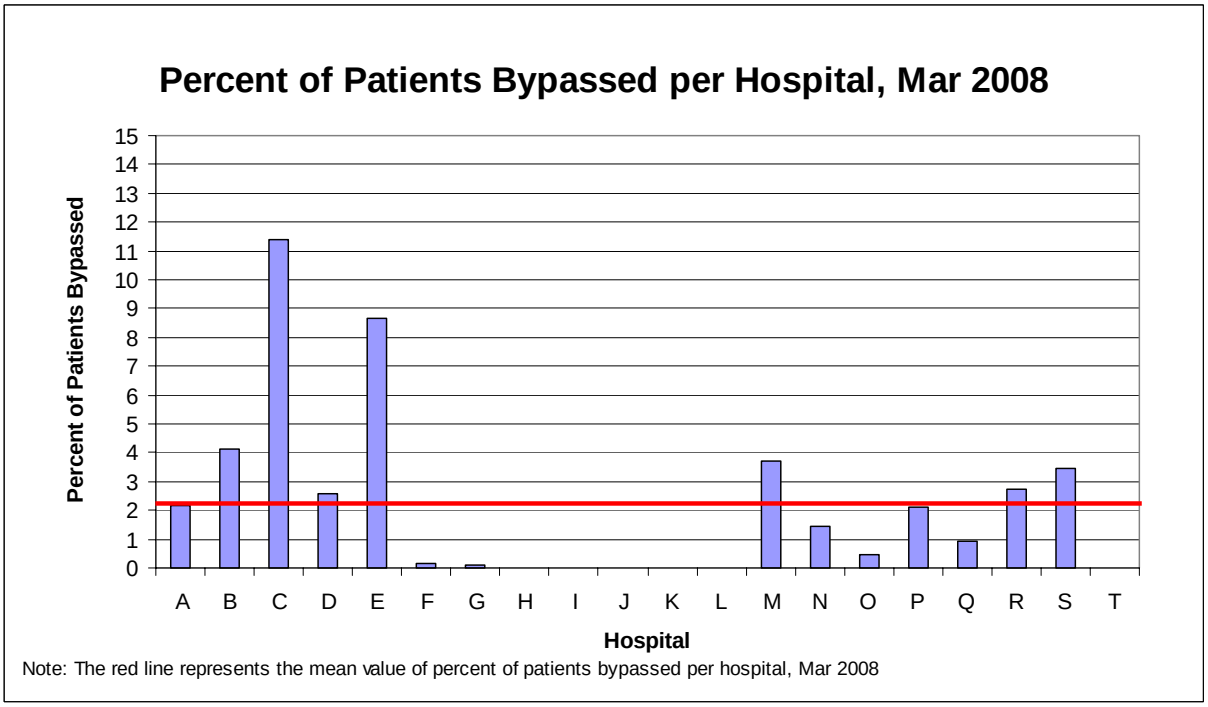

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